

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06054

Reg. Dist. No. 96

TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any detail is necessary, please execute the certificate, striking the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director.  
 forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		6973 Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Perry Point		c. LENGTH OF STAY IN 1b 3 mo. 8 days		a. STATE Maryland b. COUNTY		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Veterans Administration Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Silver Spring		
3. NAME OF DECEASED (Type or print)		First BENJAMIN	Middle P.	Last ARNOLD	4. DATE OF DEATH 9-9-15	Month June	Day 9	Year 1956
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9-9-15	9. AGE (In years last birthday) 40 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Postal		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles Sumner Arnold		14. MOTHER'S MAIDEN NAME Elizabeth M. Pettit						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Drowning</u> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH</span> <b>975X</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</b> <span style="float: right;">(b)</span> <span style="float: right;">DUE TO</span> <span style="float: right;">(c)</span> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)</b>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>R. C. Dodson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>6-12-56</i>				
EXAMINER'S NAME (Type) R. C. DODSON		22a. BURIAL, CREMATION, REMOVAL (Specify) Removal						
22b. DATE THEREOF 6-12-56		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or county) Arlington, Va.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bennington &amp; Son, Havre de Grace, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE 6-13-56		24b. REGISTRAR'S SIGNATURE <i>James E. Dougherty</i>		

DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 15 1958

RECEIVED

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained by the hospital or attending physician.

1

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

Item 12, Film G200 7-16-56 et

06055

**CERTIFICATE OF DEATH**

Reg. Dist. No. 92

6964

**1. PLACE OF DEATH**

COUNTY **Cecil**  
 CITY (If outside corporate limits, write RURAL  
 OR  
 and give nearest town)  
 TOWN **Elkton**

**MARYLAND**

LENGTH OF STAY  
 (in this place)  
**10 yrs**

**HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS****200 East Main St.****2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE **Maryland** COUNTY **Cecil**  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN **Elkton**

STREET  
 ADDRESS  
 (If rural give location)

**200 East Main Street****3. NAME OF  
 DECEASED  
 (Type or Print)**

(First) **Marie** (Middle) **T.** (Last) **Ash**

**4. SEX****F****6. COLOR OR  
 RACE****W****7. SINGLE, MARRIED,  
 WIDOWED, DIVORCED,  
 (Specify)****Married****8. DATE OF BIRTH****June 5, 1917****9. AGE last birthday****39 yrs.****IF UNDER 1 YEAR****Months****IF UNDER 24 HRS.****Days****Hours****Min.****10e. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) **Housewife****10b. KIND OF BUSINESS  
 OR INDUSTRY****11. BIRTHPLACE (State or foreign country)****Novan, Ireland****12. CITIZEN OF WHAT COUNTRY?****U.S.A.****13. FATHER'S NAME****John M. O'Donnell****14. MOTHER'S MAIDEN NAME****Nora Collins****15. WAS DECEASED EVER IN U.S. ARMED FORCES?**

(Yes, no, or unk.)

(If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.****17. INFORMANT & ADDRESS****G. Reynolds Ash, 200 E Main, Elkto****INTERVAL BETWEEN  
 ONSET AND DEATH****4 yrs.****I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH****201X IMMEDIATE CAUSE****(A)**

ANTECEDENT CAUSE(S) DUE TO

**DISEASES OR CONDITIONS, IF ANY, (B)****GIVING RISE TO THE ABOVE CAUSE****STATING UNDERLYING CAUSE LAST, DUE TO****(C)****18. MEDICAL CERTIFICATION****Hodgson's Disease Fatalized****II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.****19e. DATE OF OPERATION****19b. MAJOR FINDINGS OF OPERATION****20. AUTOPSY?**YES  NO **21e. ACCIDENT WAS UNDERLYING  
 OR CONTRIBUTING CAUSE OF DEATH  
 (If either, NOTIFY MEDICAL EXAMINER)****21b. PLACE (Home, farm, factory,  
 OF INJURY street, office bldg., etc.)****21c. WHERE DID INJURY OCCUR? (City or town)**

(County)

(State)

**21d. TIME OF INJURY (Month) (Day) (Year) (Hour)****21e. INJURY OCCURRED****21f. HOW DID INJURY OCCUR?**M. While at work  Not while at work 

**22. I hereby certify that I attended the deceased from Sept. 19, 1952, to 27 June, 1956, that I last saw the deceased alive on 26 JUNE, 1956, and that death occurred at 7:55 AM, from the causes and on the date stated above.**

**SIGNATURE****George J. Krew Jr.****ADDRESS (Street, city, town, state)****DATE SIGNED****M.D.****2018 Main St. Elkton****27 June 56****23. BURIAL, CREMATION,  
 REMOVAL (SPECIFY)****Burial****DATE THEREOF****6-29-56****NAME OF CEMETERY OR CREMATORIAL****Elkton Cemetery****LOCATION (City, town, or county)****Elkton, Maryland****24. REC'D BY REGISTRAR****DATE****6/30/56****REGISTRAR'S SIGNATURE****F. R. Frazer****25. FUNERAL DIRECTOR'S SIGNATURE****W. Henry Dyer****ADDRESS****2018 Main St. Elkton**

DEPARTMENT OF THE NATIONAL GUARD OF THE STATE OF CALIFORNIA

HEADQUARTERS

1956

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

Vs A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 23, Film Gl98 6-20-56 et

## CERTIFICATE OF DEATH

6974

06056

Reg. Dist. No. 97

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Cecil	MARYLAND	North Carolina	Pender
CITY (If outside corporate limits, write RURAL OR end give nearest town)	LENGTH OF STAY (in this place)	STATE Maryland	COUNTY Cecil
TOWN Bainbridge, Md.	2 Hr 37 Min	CITY (If outside corporate limits, write RURAL end give nearest town) Rocky Point	TOWN Bainbridge, Maryland
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital	STREET ADDRESS FMX-Trailer #18		
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
Graham Charles BLANCHARD		June 15 1956	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 14 June 1956
9. AGE last birthday yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - - - -		
10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Henry Graham BLANCHARD	
14. MOTHER'S MAIDEN NAME Jeanette Elsie ROBERTS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) - - - - - (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT & ADDRESS Navy Records	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 776X IMMEDIATE CAUSE (A) Prematurity ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____			
2. Hrs 37 Min INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from 11 June 1956, to 15 June 1956, that I last saw the deceased alive on 15 June 1956, and that death occurred at 0035 M, from the causes and on the date stated above. ADDRESS (Street, city, town, state) G. T. CICALESE, LT MC USNR M. D. U.S. Naval Hospital, Bainbridge, Md. 6-15-56 Signature: G. T. Cicalese, Lt. M.C. USNR	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		NAME OF CEMETERY OR CREMATORIAL St. Andrews Cem. West Nottingham	
24. REC'D BY REGISTRAR DATE 6-15-56		LOCATION (City, town, or county) New Harrover Co. N. C. Cocoa, Cecil, Maryland REGISTRAR'S SIGNATURE Dorothy B. Bimble, C.R.A. Patterson & Son, Perryville, Md.	
25. FUNERAL DIRECTOR'S SIGNATURE DATE 6-15-56		ADDRESS 2051171X10	

STATE DEPARTMENT OF HAWAII - PARIS 15

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CHATHAM

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BUREAU V. S.

JUN 20 1955

RECEIVED

TO DEFUNCT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any detail necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6075 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06057  
96

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Pa.</i>
b. CITY/DR TOWN (If outside corporate limits, write RURAL (give nearest town) <i>Charleston</i>	c. LENGTH OF STAY IN <i>visit</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <i>Quarryville 75x-3</i>
d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF  
DECEASED  
(Type or print)  
*DALE* First  
*EUGENE* Middle  
*Boose* Last

4. DATE  
OF  
DEATH  
Month  
10  
Day  
13  
Year  
1956

5. SEX  
*M.* 6. COLOR OR RACE  
*White* 7. MARRIED  NEVER MARRIED  8. DATE OF BIRTH  
WIDOWED  DIVORCED  *1-3-1938* 9. AGE (In years  
last birthday)  
*18* yrs.

10. IF UNDER 1 YEAR  
Months  
Days  
Hours  
Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
*Warehouse Block Plant* 10b. KIND OF BUSINESS OR INDUSTRY  
*Lancaster Pa. U.S.A.* 11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?  
*U.S.A.*

13. FATHER'S NAME  
*Amory Boose* 14. MOTHER'S MAIDEN NAME  
*Elsa Hassel*

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)  
*No* 16. SOCIAL SECURITY NO.  
*—* 17. INFORMANT  
*Grace Grindler* Address  
*Quarryville Pa.*

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) *Drowned* DUE TO  
*929.8*  
Conditions, if any, which  
gave rise to immediate cause  
(b)  
(c)  
DUE TO  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

INTERVAL BETWEEN  
ONSET AND DEATH

19. WAS AUTOPSY  
PERFORMED?  
YES  NO

20a. EXTERNAL CAUSE WAS  
PRIMARY  CONTRIBUTING  CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
*Jumped off Boat into river*

20c. TIME OF INJURY Month, Day, Year  
Hour a. m. *6-13* 19 *56* 20d. INJURY OCCURRED While Not while  
at work  at work  20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
*Front art fire Charlestown Cecil Md.* 20f. (City or town)  
(County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and find that death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined cause

ACTUAL  
SIGNATURE *R. C. Dodson* M.D. CHIEF MEDICAL EXAMINER   
EXAMINER'S  
NAME (Type) *R. C. Dodson* M.D. ASSISTANT MEDICAL EXAMINER   
DEPUTY MEDICAL EXAMINER   
DATE SIGNED *6-15-56*

22a. BURIAL, CREMATION  
REMOVAL (Specify)  
*Civil* 22b. DATE THEREOF *6-17-1956* 22c. NAME OF CEMETERY OR CREMATORIAL  
*Longmeadow* 22d. LOCATION (City, town, or county)  
*Lancaster Co. Pa.* (State)

23. FUNERAL DIRECTOR'S SIGNATURE  
*Leera Patterson & Son, Perryville, Md.* ADDRESS  
24a. REC'D BY REGISTRAR  
DATE *6-16-56* 24b. REGISTRAR'S SIGNATURE  
*Irene E. Daugherty*

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FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE - BOSTON  
JUN 19 1956

BUREAU V. S.  
RECEIVED  
JUN 19 1956

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

6965

## **CERTIFICATE OF DEATH**

06058

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>30 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>234 East Main Street</b>			d. STREET ADDRESS <b>234 East Main Street</b>		
3. NAME OF DECEASED (Type or print) <b>Tyson</b>		First <b>M.</b>	Middle <b>Boulden</b>	Last <b>Boulden</b>	4. DATE OF DEATH <b>June 18, 1956</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 1, 1897</b>	9. AGE (In years last birthday) <b>59</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Water plant Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Town of Elkton</b>		11. BIRTHPLACE (State or foreign country) <b>Cecilton, Md.</b>	
13. FATHER'S NAME <b>Lambert Boulden</b>			14. MOTHER'S MAIDEN NAME <b>Harriet Davis</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217073337</b>		17. INFORMANT <b>Mrs Elizabeth Boulden (W)</b> Same address	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>193X</b> DUE TO <b>Brein tumor - malignant glioma, left</b> INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>frontal - temporal region</b> 8 months (c) <b>44</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>left. 19, 1955</b> to <b>June 17, 1956</b> , that I last saw the deceased alive on <b>June 17, 1956</b> , and that death occurred at <b>4:20 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>222 E. Main St, Elkton, Md.</b> DATE SIGNED <b>6/18/56</b>					
ACTUAL SIGNATURE <b>S. Ralph Anderson Jr.</b> M.D.					
PHYSICIAN'S NAME (Type) <b>S. Ralph Anderson Jr. M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-21-56</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Gilpin Manor Cem.</b>	
22d. LOCATION (City, town, or county) <b>Elkton, Maryland</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry Lippin</b>			ADDRESS <b>Elkton Md</b>		24a. REC'D BY REGISTRAR DATE <b>6/20/56</b>
					24b. REGISTRAR'S SIGNATURE <b>H. Frazer</b>

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be recorded by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED - CERTIFICATE OF SERVICE

BUREAU V. E.

JUN 22 1956

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. After this bottom copy is be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6966 CERTIFICATE OF DEATH

66059

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY		MARYLAND		STATE		Maryland COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		Cecil	
TOWN		Elkton		IPAY		Cherry Hill	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				(If rural give location)			
Union Hospital							
3. NAME OF DECEASED (Type or Print)				4. DATE (Month) (Day) (Year)			
(First)		(Middle)		(Last)		June 22 1956	
Frank		W.		Brown			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
male	white	Widowed	Aug 28, 1878	77 yrs.	Months	Days	Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
Retired				Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Harry M. Brown (deceased)				Louise Willis (deceased)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.			
No				none			
17. INFORMANT & ADDRESS				18. MEDICAL CERTIFICATION			
clement H. Brown Elkton, Maryland							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) Ventricular fibrillation 3 minutes							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, (B) Massive myocardial infarction 12 hours							
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C) Coronary occlusion 12 hours							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pulmonary edema,							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21c. WHERE DID INJURY OCCUR? (City or town)				(County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
21f. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from June 21, 1956, to June 22, 1956, that I last saw the deceased alive on June 22, 1956, and that death occurred at 7:45 AM from the causes and on the date stated above. SIGNATURE <i>wallace</i> ADDRESS (Street, city, town, state) DATE SIGNED <i>Obenshain</i> 23 June 56 M.D. Cecilton, Md.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF NAME OF CEMETERY OR CREMATORIAL Burial June 25, 1956 Gilpin Manor			
24. REC'D BY REGISTRAR DATE 6/25/56				LOCATION (City, town, or county) Elkton, Cecil Co., Md			
REGISTRAR'S SIGNATURE <i>JR Frazer</i>				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Joseph R. Scott</i> North East, Md			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06060

96

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Penna.</b>		b. COUNTY <b>York</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Maryland</b>		c. LENGTH OF STAY IN 1b <b>44 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delta</b>		d. STREET ADDRESS <b>None</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Harry</b>	Middle <b>W.</b>	Last <b>Butler</b>	4. DATE OF DEATH	Month <b>6</b>	Day <b>1</b>	Year <b>1956</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-22-94</b>	9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months <b>6</b>	IF UNDER 24 HRS. Hours <b>0</b>	IF UNDER 24 HRS. Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Delta, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John T. Butler</b>				14. MOTHER'S MAIDEN NAME <b>Lillie Watson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	16. SOCIAL SECURITY NO. <b>WW-1 218-18-4733</b>	17. INFORMANT <b>Hospital Records, VAH, Perry Point, Maryland</b>	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b>							
DUE TO <b>154X</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Carcinoma of Rectum</b>							
DUE TO (c)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Cardiff</b>	(County) <b>Maryland</b>
21. I certify that I attended the deceased from <b>4-18-</b> , 1956, to <b>6-1-</b> , 1956, <b>John Harkins, the deceased</b> <b>John Harkins, the deceased</b> , and that death occurred at <b>8:40 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>W. Oppler</i>	M.D.						
PHYSICIAN'S NAME (Type) <b>W. Oppler, M.D., Owner, Professional Services, VA Hospital, Perry Point, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>6-2-56</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Slate Ridge Cemetery</b>	22d. LOCATION (City, town, or county) <b>Cardiff, Maryland</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Harkins</i>	ADDRESS <b>JOHN HARKINS FUNERAL DIRECTOR, Delta, Pa.</b>	24a. REC'D BY REGISTRAR DATE <b>6-2-56</b>					
						24b. REGISTRAR'S SIGNATURE <i>Suzanne E. Daugherty</i>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.VS A15 (4)  
15M 9/55

A34

## CERTIFICATE OF DEATH

BUREAU V. S.

JUN 4 1955

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06061

## 6077 CERTIFICATE OF DEATH

Reg. Dist. No. 95

## 1. PLACE OF DEATH

COUNTY **Cecil**  
 CITY (If outside corporate limits, write RURAL  
 OR and give nearest town)  
 TOWN **Rising Sun** Rural

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS

MARYLAND

LENGTH OF STAY  
 (in this place)  
**42 yrs.**

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE **Md.** COUNTY **Cecil**

CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN **Rising Sun** Rural

STREET  
 ADDRESS  
 (If rural give location)

3. NAME OF  
 DECEASED  
 (Type or Print)

(First) **John** (Middle) **Newton**

(Last) **Cameron**

4. DATE (Month) (Day) (Year)  
**June 9 1956**

5. SEX **Male**6. COLOR OR  
 RACE **White**7. SINGLE, MARRIED,  
 WIDOWED, DIVORCED,  
 (Specify) **Married**8. DATE OF BIRTH  
**Sept. 13, 1878**9. AGE last birthday  
**77 yrs.**

IF UNDER 1 YEAR  
 Months **0** Days **0** Hours **0** Min. **0**

10a. USUAL OCCUPATION (Give kind of work  
 done during most of working life, even if  
 retired) **Retired Farmer**10b. KIND OF BUSINESS  
 OR INDUSTRY  
**Owner**11. BIRTHPLACE (State or foreign country)  
**Hicksville Va.**12. CITIZEN OF WHAT  
 COUNTRY? **U.S.**

## 13. FATHER'S NAME

**Joseph Cameron**

## 14. MOTHER'S MAIDEN NAME

**Katherine Kidd.**15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
 (Yes, no, or unk.) **No** (If Yes, give war or dates of service)16. SOCIAL SECURITY NO.  
**214-34-3753**

## 17. INFORMANT &amp; ADDRESS

**Mrs. John Cameron** **Rising Sun, Md.**

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

**331X** IMMEDIATE CAUSE **(A)** *Cardiac Decompensation*  
 ANTECEDENT CAUSE(S) DUE TO **(B)** *Cerebral vascular accident*  
 DISEASES OR CONDITIONS, IF ANY, **(B)**  
 GIVING RISE TO THE ABOVE CAUSE DUE TO  
 STATING UNDERLYING CAUSE LAST. **(C)**

INTERVAL BETWEEN  
 ONSET AND DEATH**3 days****8 months**II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
 YES  NO 21a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
 (If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
 OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

## 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
 While  at work  Not while  at work

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Oct. 19, 55** to **June 10, 1956**, that I last saw the deceased

alive on **June 9, 1956**, and that death occurred at **10 a.m.** from the causes and on the date stated above.

SIGNATURE *Neil Tandy*ADDRESS (Street, city, town, state) *Rising Sun, Md.*DATE SIGNED *6/11/56*23. BURIAL, CREMATION,  
 REMOVAL (SPECIFY)  
**Burial**

DATE THEREOF

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county)

(State) *Near Rising Sun, Md.*

## 24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

## 25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE *6-13-56*REGISTRAR'S SIGNATURE *Louise Worthington*FUNERAL DIRECTOR'S SIGNATURE *J. Earl Tyson*ADDRESS *Rising Sun, Md.*

EX-46-415

6163

BUREAU V. S.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06062

92

6078

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CECIL		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Elkton, Md.		b. COUNTY Cecil	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Elkton, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ARTHUR	Middle CROUSE	Last Month June Day 27 Year 1956
4. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 14, 1872
9. AGE (In years lost birthday) 84	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country) North Carolina
13. FATHER'S NAME Martin Crouse	14. MOTHER'S MAIDEN NAME Adeline Hill	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Verdie Crouse, R. D. 4 Elkton, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 days	
(b) DUE TO Cerebrovascular - Hypertension		5 yrs.	
(c) Benign. Hypertrophy Prostate			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>20 Dec</u> , 19 <u>55</u> , to <u>27 June</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>25 June</u> , 19 <u>56</u> , and that death occurred at <u>75 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George J. Dreis, M.D.</i>	ADDRESS (Street, city or town, state) M.D. <u>201 E. Main St.</u> DATE SIGNED <u>27 June 56</u>		
PHYSICIAN'S NAME (Type) George J. Dreis, M. D.	201 E. Main Street, Elkton, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 1, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Cherry Hill Meth. Cem.	22d. LOCATION (City, town, or county) Cecil County, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph E. Hicks</i>	ADDRESS 103 Stockton St. Elkton	24a. REC'D BY REGISTRAR DATE 6/30/56	24b. REGISTRAR'S SIGNATURE <i>JR Frazer</i>

## CERTIFICATE OF DEATH

PLACE &  
DATENAME OF  
DECEASEDNAME OF  
DOCTOR

NAME OF HOSPITAL

NAME OF DOCTOR

BUREAU Y

JUL 5 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06063

6979

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 27 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) V.A. Hospital, Perry Point, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace	
3. NAME OF DECEASED (Type or print) First RAYMOND		Middle F.	4. DATE OF DEATH CULLUM Month June Day 5 Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-27-12
9. AGE (In years from birth) 44 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aide		10b. KIND OF BUSINESS OR INDUSTRY Occupational Therapy	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Cullum		14. MOTHER'S MAIDEN NAME Effie Gray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Bronchogenic carcinoma, left upper bronchus		INTERVAL BETWEEN ONSET AND DEATH unknown	
(c)		unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. VA 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 9, 1956, to June 5, 1956, and that death occurred at 1:19 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Oppler		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 6-5-56	
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-5-56	
22c. NAME OF CEMETERY OR CREMATORIAL Rock Run		22d. LOCATION (City, town, or county) Rock Run, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Madison R. Mitchell		ADDRESS Madison R. Mitchell, Havre de Grace, Md.	24a. REC'D BY REGISTRAR DATE 6/5/56
		24b. REGISTRAR'S SIGNATURE Irene E. Daugherty	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6080

## CERTIFICATE OF DEATH

06064

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland		c. LENGTH OF STAY IN 1b 63 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frank (Jr.)		First	Middle	4. DATE OF DEATH Lost DI GIOVANNI	Month June	Day 6	Year 19 56
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-14-20	9. AGE (In years lost birthday) 36 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Distributor		10b. KIND OF BUSINESS OR INDUSTRY Beer & Wine		11. BIRTHPLACE (State or foreign country) Havre De Grace, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Di Giovanni (Deceased)		14. MOTHER'S MAIDEN NAME Jennie Sablone (Deceased)					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes		16. SOCIAL SECURITY NO. WW-11		17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 0 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____		4-3-1956		to 6-6-1956		, and that death occurred at 4:45 AM, from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>W. Oppler</i>						ADDRESS (Street, city or town, state) M.D. V.A. Hospital, Perry Point, Md.	
PHYSICIAN'S NAME (Type) W. OPPLER						DATE SIGNED 6/6/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-6-56		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Erin		22d. LOCATION (City, town, or county) Havre De Grace, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee A. Patterson</i>		ADDRESS Lee A. Patterson & Son, Perryville, Maryland		24a. REC'D BY REGISTRAR DATE 6-6-56		24b. REGISTRAR'S SIGNATURE <i>Dorothy E. Langlois</i>	

## CERTIFICATE OF DEATH

Place	Date	Age	Sex	Color	Signature
1	2	3	4	5	6
7	8	9	10	11	12
13	14	15	16	17	18
19	20	21	22	23	24
25	26	27	28	29	30
31	32	33	34	35	36
37	38	39	40	41	42
43	44	45	46	47	48
49	50	51	52	53	54
55	56	57	58	59	60
61	62	63	64	65	66
67	68	69	70	71	72
73	74	75	76	77	78
79	80	81	82	83	84
85	86	87	88	89	90
91	92	93	94	95	96
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80467	80468	80469	80470	80471	80472
80473	80474	80475	80476	80477	80478
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6081

## CERTIFICATE OF DEATH

06065

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rising Sun</i>		c. LENGTH OF STAY IN 1b <i>15 yrs</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>md</i>		b. COUNTY <i>Cecil</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rising Sun</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		d. STREET ADDRESS <i>Reynolds Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <i>James</i>		First <i>James</i>	Middle <i>Lee</i>	Last <i>Ewing</i>	4. DATE OF DEATH <i>June 4 1956</i>	Month <i>June</i>	Day <i>4</i>	Year <i>1956</i>	5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 13, 1880</i>	9. AGE (In years lost birthday) <i>75 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>	12. BIRTHPLACE (State or foreign country) <i></i>	13. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>Elwood Ewing</i>		14. MOTHER'S MAIDEN NAME <i>Anna Kennard</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>mrs Marion Rawlings, Rising Sun, Md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cerebral Hemorrhage</i> <i>Arteriosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Rising Sun</i>		(County) <i>Caroline</i>		(State) <i>MD</i>							
21. I certify that I attended the deceased from <i>Jan 14, 1956</i> to <i>Jan 14, 1956</i> , that I last saw the deceased alive on <i>Jan 4, 1956</i> , and that death occurred at <i>Rising Sun</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Rising Sun</i> M.D. <i>6-5-56</i>												DATE SIGNED <i>6-5-56</i>					
ACTUAL SIGNATURE <i>R.C. Dodson, M.D.</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>										22b. DATE THEREOF <i>6/17/56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Harmony Cemetery</i>	22d. LOCATION (City, town, or county) <i>Rolandsville</i>	(State) <i>md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph M. Reed</i>		ADDRESS <i>Rising Sun, md</i>		24a. REGISTERED BY REGISTRAR <i>6/17/56</i>		24b. REGISTRAR'S SIGNATURE <i>L.M. Washington</i>											

## CERTIFICATE OF DEATH

DEATH

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RECEIVED  
JUN 7 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6982 CERTIFICATE OF DEATH

06066  
96  
Reg. Dist. No. ✓

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>30 yrs. 11 mo. 8 days</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				
3. NAME OF DECEASED (Type or print) <b>CHARLES</b>		First <b>W.</b>	Middle <b>FOXWELL</b>			
4. DATE OF DEATH <b>8-23-86</b>		Month <b>June</b>	Day <b>6</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>8-23-86</b>		9. AGE (In years lost/birthday) <b>69</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Charles Foxwell</b>				
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				
16. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, unresolved</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b>				
DUE TO <b>420.1</b>						
Conditions, if any, which gave rise to immediate cause (a), stating the under- (b) <b>Coronary sclerosis severe</b>		unknown				
DUE TO (c) <b>Tuberculosis pulmonary with cavitation, left upper lobe</b>		unknown				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>002x</b>		19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>VAH, Perry Point, Md.</b>	20f. (City or town) <b>VAH, Perry Point, Md.</b>	(County)	(State)
21. I certify that I attended the deceased from <b>June 29</b> , 19 <b>25</b> , to <b>June 6</b> , 19 <b>56</b> , and that death occurred at <b>2:35 PM</b> , from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>W. Oppler</i>		ADDRESS (Street, city or town, state) <b>VAH, Perry Point, Md.</b>		DATE SIGNED <b>6-7-56</b>		
PHYSICIAN'S NAME (Type) <b>W. OPPLER</b>		Director, Professional Services				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6-7-56</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lilly &amp; Zeiler Funeral Home, Baltimore, Md.</b>		ADDRESS <b>Lilly &amp; Zeiler Funeral Home, Baltimore, Md.</b>		24a. REC'D BY REGISTRAR <b>MM 8 1956</b>	24b. REGISTRAR'S SIGNATURE <b>June 6, 1956</b>	

## CERTIFICATE OF DEATH

MURKIN

BUREAU V. 2

MAY 11 1956

RECEIVED

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the attending physician or director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician or director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 18 Film G200 7-20-56 ams 6957

06067

Reg. Dist. No. 92

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 7 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton-rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS R. D. #3		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Homer	Middle Vincent	Lost France	4. DATE OF DEATH	Month June	Day 27, 1956
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-10-01		9. AGE (In years lost 54 yrs.)	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman Store Kpr		10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Vermont, Ill.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME France		14. MOTHER'S MAIDEN NAME Cloie McCormick					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Mrs Sarah G. France, RD 3, Elkton, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 573X DUE TO Bronchial asthma Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Chronic Semiretention (c)		INTERVAL BETWEEN ONSET AND DEATH (4 mos., 20 days) 12 yrs plus					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Elkton	(County) (State)
21. I certify that I attended the deceased from <u>July 21, 1956</u> to <u>July 21, 1956</u> that I last saw the deceased alive on <u>July 21, 1956</u> and that death occurred at <u>Elkton, Maryland</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Henry D. Gilpin</u>				ADDRESS (Street, city or town, state) <u>Elkton, Maryland</u>		DATE SIGNED <u>7-1-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-1-56	22c. NAME OF CEMETERY OR CREMATORIAL Gilpin Manor Cem.		22d. LOCATION (City, town, or county) (State) Elkton, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Henry Gilpin</u>		ADDRESS <u>259 E. Main St. Elkton, Maryland</u>	24a. REC'D BY REGISTRAR DATE <u>6/30/56</u>		24b. REGISTRAR'S SIGNATURE <u>H. Frazer</u>		

BUREAU OF  
REGISTRATION

112 1956

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **72 hours** after death. After this bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06068

## 6968 CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY		MARYLAND		STATE		COUNTY	
Cecil				Maryland		Cecil	
CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		STREET ADDRESS	
Elkton		3 yrs		Elkton		223 East Main Street (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				223 East Main Street			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH June 18, 1956			
5. SEX F		6. COLOR OR RACE W		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) S		8. DATE OF BIRTH March 11, 1953	
9. AGE last birthday 3 yrs.		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elkton, Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Donald M. Gee				14. MOTHER'S MAIDEN NAME Constance G. Garvin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Donald M. Gee			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
754.4 IMMEDIATE CAUSE (A)				18. MEDICAL CERTIFICATION			
ANTECEDENT CAUSE(S) DUE TO				Cardiac failure			
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO				Congenital Heart Disease			
(C)				2 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
Nephrosis				2 mos			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
21f. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from.....19....., to.....18 June 1956....., that I last saw the deceased alive on.....14 June 1956....., and that death occurred at.....6 P.M....., from the causes and on the date stated above.							
SIGNATURE <i>Clifton R. Brooks</i> ADDRESS (Street, city, town, state) <i>269 E. Main St Newark Del.</i> DATE SIGNED <i>19 June 56</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIES) Burial		DATE THEREOF 6-20-56		NAME OF CEMETERY OR CREMATORIAL Gilpin Manor Cem.		LOCATION (City, town, or county) Elkton, Maryland (State)	
24. REC'D BY REGISTRAR DATE 6/20/56		REGISTRAR'S SIGNATURE <i>J. R. Frazer</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Henry Gilpin Elkton, Md</i>		ADDRESS	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06069

Reg. Dist. No. 97

6083

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge		c. LENGTH OF STAY IN lb --		a. STATE Pennsylvania b. COUNTY Lancaster	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Providence		c. STREET ADDRESS Box #26	
d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JEFFREY		First	Middle	Last	4. DATE OF DEATH HELM
5. SEX Male		6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-3-56	9. AGE (In years last birthday) yrs. 6
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Charles Henry HELM		14. MOTHER'S MAIDEN NAME Mabel Ellen ERB			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. -----		17. INFORMANT Navy Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X		INTERSTITIAL PNEUMONIA ?			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
ACTUAL SIGNATURE R. C. DODSON		DATE SIGNED 6-4-56			
EXAMINER'S NAME (Type) R. C. DODSON, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL & BURIAL REMOVAL & BURIAL		22b. DATE THEREOF 6-6-56		22c. NAME OF CEMETERY OR CREMATORIUM Zion Reformed Cemetery	
22d. LOCATION (City, town, or county) New Providence, Pennsylvania		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Lee Patterson & Son, Perryville, Md.		ADDRESS 2051252 XV5		24a. REC'D BY REGISTRAR DATE 6-5-56	
				24b. REGISTRAR'S SIGNATURE Dorothy Bramble	

THE FEDERAL BUREAU OF INVESTIGATION - U. S. DEPARTMENT OF JUSTICE

BUREAU Y. L.

9051 2 NII

REGEV ED  
1956

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

060781

Reg. Dist. No.

**TO DEPARTMENTAL MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any detail is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesapeake City</b>		c. LENGTH OF STAY IN 1b <b>50 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
3. NAME OF -DECEASED (Type or print) <b>Holden</b>		First <b>Holden</b>	Middle <b>Spry</b>
		Lost <b>Ireland</b>	4. DATE OF DEATH Month <b>6</b>
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>6-3-1869</b>
		WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (State or foreign country) <b>Kent Co. Md.</b>
13. FATHER'S NAME  <b>No information</b>		14. MOTHER'S MAIDEN NAME  <b>No information</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.  <b>-----</b>	17. INFORMANT  <b>John H. Harrison, Chesapeake City Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address  <b>Acute Coronary</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  <b>420.1</b>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  <b>(b)</b>		DUE TO  <b>Aterio Sclerosis</b>	
DUE TO  <b>(c)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED?  <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>a. m.</b> <b>p. m.</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  <b>(City or town) (County) (State)</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R.C. Dodson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		DATE SIGNED <b>6-11-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-14-56</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Galena Cemetery</b>
22d. LOCATION (City, town, or county)  <b>Galena</b>		(State)  <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE  <b>John Henry Lippin Elkton, Md</b>		24a. RECEIVED BY REGISTRAR  <b>June 14/56</b>	24b. REGISTRAR'S SIGNATURE  <b>Miss Barbara H. Lee</b>

RECEIVED - MAIL ROOM - STATE OF KANSAS - 18 JUN 1956  
KANSAS STATE CERTIFICATE OF ELECTION

BUREAU V. S.

JUN 18 1956

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. After this bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6069

## CERTIFICATE OF DEATH

06071

Reg. Dist. No. 92

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY	Cecil	MARYLAND	STATE	Maryland	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN	Elkton	2 days	TOWN	Elkton	- Rural
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Elkton Hospital		STREET ADDRESS	(If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE (Month) (Day) (Year)	
	David	D	Jackson	June 20, 1956	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR Months
M	W	Single	June 18, 1956	yrs.	Days
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	
				Elkton, Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Clarence Jackson			Martha Lynn Gill		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS	
No				Clarence Jackson	
18. MEDICAL CERTIFICATION					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
776X IMMEDIATE CAUSE (A) Prematurity					
ANTECEDENT CAUSE(S) DUE TO					
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE					
STATING UNDERLYING CAUSE LAST. DUE TO (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 18, 1956</u> to <u>June 20, 1956</u> , that I last saw the deceased alive on <u>June 19, 1956</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Donald Sprecher</u> M.D.					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)			DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county) (State)
Burial			6-22-56	North East Cemetery	North East, Md.
24. REC'D BY REGISTRAR			REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE 6/25/56			H. Frazer	H. Henry Tippin	Elkton Md.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, Film G199 7-5-56 et See: Birth Cert.

06072

6085

## CERTIFICATE OF DEATH

Reg. Dist. No. 97

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey		b. COUNTY Union			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge		c. LENGTH OF STAY IN 1b 45 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEWBORN		d. STREET ADDRESS 9 Smith Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First JOHN	Middle NONE	Last KELLER	4. DATE OF DEATH June	Month 25	Day 19	Year 56	
5. SEX Male		6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-25-56	9. AGE (In years lost birthday) yrs. 45	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---			10b. KIND OF BUSINESS OR INDUSTRY ---			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Florian Frank Keller			14. MOTHER'S MAIDEN NAME Mary Bridget Mitchell			Address Navy Records			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT ACHONDROPLASTIC DWARF		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 158.1 DUE TO ACHONDROPLASTIC DWARF INTERVAL BETWEEN ONSET AND DEATH 45 min.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) U. S. Naval Hospital, Bainbridge, Md.	(County)	(State)
21. I certify that I attended the deceased from 6-25, 1956, to 6-25, 1956, that I last saw the deceased alive on 6-25-56, 19, and that death occurred at 0700 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) J. M. PLUKAS LT MC USNR 6/26/56									
ACTUAL SIGNATURE <i>J. M. Plukas</i>		M.D.		DATE SIGNED					
PHYSICIAN'S NAME (Type) J. M. PLUKAS LT MC USNR									
22a. BURIAL, CREMATION, REMOVAL & BURIAL Removal & Burial 6-26-56		22b. DATE THEREOF 6-26-56		22c. NAME OF CEMETERY OR CREMATORIUM West Nottingham		22d. LOCATION (City, town, or county) Colora, Cecil Co., Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee A. Patterson &amp; Son, Perryville, Md.</i>		ADDRESS 2051211 XV4		24a. REC'D BY REGISTRAR D. Bramble DATE 6-26-56		24b. REGISTRAR'S SIGNATURE <i>D. Bramble</i>			



**INSTRUCTIONS****TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death.**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

06073

**CERTIFICATE OF DEATH**

Reg. Dist. No. 92

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	cecil Elkton Union Hospital	MARYLAND LENGTH OF STAY (in this place)	STATE Maryland COUNTY Cecil CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN North East STREET ADDRESS Rt #2
<b>3. NAME OF DECEASED</b> (First) EDWARD (Middle) (Last) LYNCH		<b>4. DATE (Month) (Day) (Year)</b> OF DEATH June 12 1956	
S. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower	8. DATE OF BIRTH August 4, 1878
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician Retired P.A.R.		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 77 yrs.
13. FATHER'S NAME Thomas Lynch		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? 254
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Pulmonary edema		2 days	
ANTECEDENT CAUSE(S) DUE TO (B) Cardiac vascular renal		10 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (C)			
STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from ..... 1956, to 6/17, 1956, that I last saw the deceased alive on ..... 12, 1956, and that death occurred at 10 P.M. from the causes and on the date stated above.			
SIGNATURE <i>John Beattie Bates</i> ADDRESS (Street, city, town, state) M.D. Pectoral DATE SIGNED 7/13/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 6-15-56	NAME OF CEMETERY OR CREMATORIAL Methodist	LOCATION (City, town, or county) North East (State) MD
24. REC'D BY REGISTRAR DATE 6/15/56	REGISTRAR'S SIGNATURE H. Fraser	25. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Scott	ADDRESS North East MD

CERTIFICATE OF DATE

BUREAU V. S.  
JUN 19 1955  
RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. After this bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AIFC 155 10W

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06074

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	CECIL	MARYLAND	STATE MARYLAND COUNTY CECIL
CITY (If outside corporate limits, write RURAL or end give nearest town)	LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN ELKTON	1 DAY		OR TOWN RURAL ELKTON RFD #4
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)		
3. NAME OF DECEASED (First) SARAH (Middle) JAYNE (Last) Miles.		4. DATE (Month) (Day) (Year) OF DEATH Jun 18 1956	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH June 17, 1956
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday yrs. IF UNDER 1 YEAR' IF UNDER 24 HRS.
NONE			Months Deys Ho Min.
13. FATHER'S NAME CHARLES MILES		11. BIRTHPLACE (State or foreign country) MARYLAND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		14. MOTHER'S MAIDEN NAME BETTY EKLAND	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS CHARLES MILES ELKTON, MD RFD #4	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 754.4 IMMEDIATE CAUSE (A) Congenital Heart Defect - Birth			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) _____			
STATING UNDERLYING CAUSE LAST. DUE TO (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19e. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 17, 1956, to June 18, 1956, that I last saw the deceased alive on June 18, 1956, and that death occurred at 11:45 a.m. from the causes and on the date stated above.			
SIGNATURE <i>Johnford Sprecher</i> M.D. ADDRESS (Street, city, town, state) DATE SIGNED June 18, 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF JUNE 19, 1956	NAME OF CEMETERY OR CREMATORIUM PRESBYTERIAN
24. REC'D BY REGISTRAR DATE 6/21/56		REGISTRAR'S SIGNATURE <i>H. Sprecher</i>	LOCATION (City, town, or county) CHRISTIANA, DEL. (State)
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>R. T. Jones Newark, Del.</i>		REGISTRAR'S SIGNATURE	

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أَتَاهُنَّ مِنْ مَالٍ أَنْ يَنْعَلِمُوا  
أَنَّمَا يَنْعَلِمُونَ مَا لَمْ يُكْفِرُوا  
أَنَّمَا يَنْعَلِمُونَ مَا لَمْ يَعْلَمُوا

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**6986 CERTIFICATE OF DEATH**

06075

Reg. Dist. No.

97

1. PLACE OF DEATH a. COUNTY <b>CECIL</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MINNESOTA</b> b. COUNTY <b>ROSEAU</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BAINBRIDGE</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROSEAU</b>		60 X 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>ROSE</b>		First <b>ROSE</b>	Middle <b>MARIE</b>	Last <b>OLSON</b>	4. DATE OF DEATH <b>June 25 1956</b>	Month <b>June</b>	Day <b>25</b>	Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2-23-58</b>	9. AGE (In years last birthday) <b>18</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. MIN. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Albert S. Olson</b>				14. MOTHER'S MAIDEN NAME <b>Deceased and unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>6-18-56 to present</b>		17. INFORMANT <b>Navy Records</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DIABETES MELLITUS</b> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH</span>  260 X DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)  DUE TO  (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Warroad</b>	(County) <b>Roseau Co.</b>	(State) <b>Minn.</b>			
21. I certify that I attended the deceased from <b>6-25-56</b> , 19 <b>56</b> , to <b>6-25-56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>6-25</b> , 19 <b>56</b> , and that death occurred at <b>12:07 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> <b>Bainbridge, Maryland</b>									DATE SIGNED <b>6-25-56</b>
ACTUAL SIGNATURE <i>J. M. Plukas</i>		M.D.							
PHYSICIAN'S (Name & Type) <b>J. M. PLUKAS, LT MC USNR</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal &amp; Burial</b>		22b. DATE THEREOF <b>6-27-56</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Riverside Cemetery</b>		22d. LOCATION (City, town, or county) <b>Warroad, Roseau Co., Minn.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leila Patterson, Kenerville, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>6-25-56</b>		24b. REGISTRAR'S SIGNATURE <i>D. Bramble</i>			

CERTIFICATE OF DEATH

BUREAU Y.

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REGISTRY

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06076

Reg. Dist. No. 92

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, utilizing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 2 and 4 with the registrar prior to burial or removal.

6072				21 65								
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>				<b>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</b> a. STATE <b>Delaware</b> b. COUNTY <b>New Castle</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newark</b> d. STREET ADDRESS <b>300 Ashley Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
<b>3. NAME OF DECEASED</b> (Type or print) <b>James</b>		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year				
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH			9. AGE (in years last birthday)	10. UNDER 1YEAR	11. UNDER 24 HRS.				
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4-19-1895			61 yr.	Months	Days	Hours	Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b>			<b>11. BIRTHPLACE</b> (State or foreign country) <b>Cecilton, Maryland</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>Fred S. Robinson</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Sadie Culp</b>			Address <b>Mrs. Katherine Robinson, 300 Ashley Rd., Newark, Delaware</b> <small>INTERVAL BETWEEN ONSET AND DEATH</small>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>221-24-4013</b>		<b>17. INFORMANT</b>								
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Penetrating bullet wound in left side of Head</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self with a .22 rifle</b>										
<b>20c. TIME OF INJURY</b> <b>1:00 p. m.</b> <b>Month, Day, Year</b> <b>6-22-1956</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		<b>20f. (City or town)</b> <b>Newark</b> <b>(County)</b> <b>New Castle</b> <b>(State)</b> <b>Delaware</b>						
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/></b>												
<b>ACTUAL SIGNATURE</b> <b>R. C. Dodson</b>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>										
<b>EXAMINER'S NAME (Type)</b> <b>R. C. Dodson,</b>		<b>DATE SIGNED</b> <b>6-22-56</b>										
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>6/25/56</b>		<b>22c. NAME OF CEMETERY OR CREMATORI</b> <b>St. Georges Cemetery</b>		<b>22d. LOCATION (City, town, or county)</b> <b>St. Georges</b> <b>(State)</b> <b>Delaware</b>						
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Yvonne Daniels Middletown Del.</b>		<b>ADDRESS</b> <b>116 X 3</b>		<b>24a. REC'D BY REGISTRAR</b> <b>6/25/56</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>J. H. Fraser</b>						
<small>VS. A15ME(5) SM 9/55</small>												

REGULAR EXAMINER'S CERTIFICATE OF DEATH  
REGULAR STATE BOARD OF MEDICAL EXAMINERS

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JUN 26 1956

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6987

## CERTIFICATE OF DEATH

66077

96

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Md.</b>		c. LENGTH OF STAY IN 1b <b>12 yrs 8 mo. 11 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale, Md.</b>		d. STREET ADDRESS <b>4707 Tuckerman Street,</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>4707 Tuckerman Street,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>JOSEPH</b>		First <b>E.</b>	Middle <b>.</b>	Last <b>SINGER</b>	4. DATE OF DEATH <b>June 22</b>	Month <b>June</b>	Day <b>22</b>	Year <b>1956</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>3-27-91</b>	9. AGE (In years from birthdate) <b>65</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Musician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Orchestra</b>		11. BIRTHPLACE (State or foreign country) <b>New York City, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Morris Singer</b>				14. MOTHER'S MAIDEN NAME <b>Minerva Levine</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1-13-15 8-31-20 Unknown</b>		17. INFORMANT <b>Veterans Administration Hospital Records</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>430.0</b>				Bronchopneumonia, right lower lobe, unresolved		INTERVAL BETWEEN ONSET AND DEATH <b>5-6 days</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)				Subacute bacterial endocarditis with vegetations in aortic cusps		unknown		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Encephalomalacia, left temporal lobe. Arteriosclerosis, general, severe</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>VA</b>				
20c. TIME OF INJURY Hour o. m. p. m.		Month <b>19</b>	Day <b>10-11-</b>	Year <b>1943</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>VAH, Perry Point, Md.</b>	20f. (City or town) <b>VAH, Perry Point, Md.</b>	
(County) <b>VAH, Perry Point, Md.</b>		(State) <b>VA</b>						
21. I certify that I attended the deceased from <b>10-11- 1943</b> to <b>6-22- 1956</b> , the date of death, and that death occurred at <b>1:50 P.M.</b> from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <b>VAH, Perry Point, Md.</b>								
DATE SIGNED <b>6-25-56</b>								
ACTUAL SIGNATURE <i>W. Oppler</i>								
PHYSICIAN'S NAME (Type) <b>W. OPPLER</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6-24-56</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington National</b>		22d. LOCATION (City, town, or county) <b>Arlington, Va.</b>		
(State) <b>VA</b>								
23. FUNERAL DIRECTOR'S SIGNATURE <i>James E. Slougherty</i>		ADDRESS <b>Chesapeake Cremation, Notre de Grace, Md.</b>		24a. REC'D BY REGISTRAR <b>6-25-56</b>		24b. REGISTRAR'S SIGNATURE <i>James E. Slougherty</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8. **ROUTINE**—**ROUTINE** **ROUTINE** **ROUTINE** **ROUTINE** **ROUTINE** **ROUTINE** **ROUTINE**

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W. H. C. -

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06078

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Item 7, Film 0199 6-25-56 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point,</b>		c. LENGTH OF STAY IN 1b <b>3 mo. 5 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
3. NAME OF DECEASED (Type or print) <b>ERNEST</b>		First <b>E.</b>	Middle <b>E.</b>
4. DATE OF DEATH <b>SPEAK</b>		Month <b>June</b>	Day <b>11</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>(Separated)</b> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>7-19-82</b>		9. AGE (In years lost birthday) <b>73 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Locomotive</b>	11. BIRTHPLACE (State or foreign country) <b>New Mexico</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Edward Speak</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret (?)</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	
16. SOCIAL SECURITY NO. <b>WV 1</b>		17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <b>36-48 hours</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>199.9</b>		DUE TO <b>Bronchopneumonia, unresolved, left lower lobe</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>(b)</b>		DUE TO <b>Carcinoma of undetermined origin with metastasis</b> unknown	
		DUE TO <b>to the right adrenal and left lung</b> unknown	
		(c) <b>Arteriosclerosis, general</b> unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 6, 1956</b> to <b>June 11, 1956</b> , and that death occurred at <b>5:43 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>VAH, Perry Point, Md.</b>	
ACTUAL SIGNATURE <i>W. M. Harris</i>		DATE SIGNED <b>6-13-56</b>	
PHYSICIAN'S NAME (Type) <b>W. M. HARRIS</b>		Actg. Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL <b>Recremation</b>		22b. DATE THEREOF <b>6-13-56</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>
22d. LOCATION (City, town, or county) <b>Arlington, Va.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pennington &amp; Son, Havre de Grace, Md.</i>		24a. REC'D BY REGISTRAR <b>Leanne E. Daugherty</b>	24b. REGISTRAR'S SIGNATURE
		DATE <b>6-15-56</b>	

DEPARTMENT OF HOMELAND SECURITY  
CERTIFICATE OF DELIVERY

BUREAU V. S.

JUN 18 1996

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

06079  
Reg. Dist. No. 96

6929

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>1 mo. 8 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>	
3. NAME OF DECEASED (Type or print) <b>VIRGIL</b>		First <b>O.</b>	Middle <b>SPENCER</b>
4. DATE OF DEATH <b>10-18-23</b>		Month <b>June</b>	Day <b>19</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>10-18-23</b>		9. AGE (In years lost birthday) <b>32</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Explosive</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ira Spencer</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Bennett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>236-26-7487</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest (after surgery)</b> INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Benign pulmonary cyst</b> unknown			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>VA</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> attended the deceased from <b>May 11, 1956</b> to <b>June 19, 1956</b> , and that death occurred at <b>7:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, Perry Point, Md.</b> DATE SIGNED <b>6-20-56</b>			
ACTUAL SIGNATURE <i>W. Oppler</i>			
PHYSICIAN'S NAME (Type) <b>W. OPPLER</b> Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL <b>Removal</b>		22b. DATE THEREOF <b>6-19-56</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Walnut Grove</b>		22d. LOCATION (City, town, or county) <b>Dille, West Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Planning &amp; Son</i>		ADDRESS <b>Havre de Grace, Md.</b>	
24a. REC'D BY REGISTRAR <b>Irene E. Daugherty</b>		24b. REGISTRAR'S SIGNATURE <b>Irene E. Daugherty</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

116080

Reg. Dist. No. 96

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Deposit</i>		c. LENGTH OF STAY IN ab <i>all life</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>399 Main St</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>HOWARD MORRISON Strout</i>		First <i>H</i>	Middle <i>Howard</i>			
4. DATE OF DEATH <i>6/17/56</i>		Month <i>6</i>	Day <i>17</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <i>10-7-1884</i>			
9. AGE (In years less birthday <i>71 yrs.</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired hardware &amp; lumber merchant</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Port Deposit Md.</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Theodore H Strout</i>	14. MOTHER'S MAIDEN NAME <i>Hate Morrison</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-03-3688</i>	17. INFORMANT <i>Family down Port Deposit</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute cerebral hemorrhage.</i>		INTERVAL BETWEEN ONSET AND DEATH				
DUE TO <i>331X</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Colora, Md.</i>	(County) <i>Colora</i>	(State) <i>Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>R.C. Dodson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>6-17-56</i>		
EXAMINER'S NAME (Type) <i>R.C. Dodson</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-20-1956</i>	22c. NAME OF CEMETERY OR CREMATORIY <i>West Nottingham</i>	22d. LOCATION (City, town, or county) <i>Colora, Md.</i>	(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Keas Patterson &amp; Son</i>	ADDRESS <i>Perryville, Md.</i>	24a. REC'D BY REGISTRAR <i>6-20-56</i>	24b. REGISTRAR'S SIGNATURE <i>Irene E. Daugherty</i>			

MANHATTAN STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S OFFICE

BUREAU V. 2

UN 21 1956

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. After this The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6091

## CERTIFICATE OF DEATH

06081

Reg. Dist. No. 95

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY Cecil		MARYLAND		STATE Md.		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN Rising Sun		30 yrs.		TOWN Rising Sun		TOWN Rising Sun	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE (Month) (Day) (Year)</b>			
Mary Ethel Wilson				June 11 1956			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH July 8 1889	9. AGE last birthday 66 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				11. BIRTHPLACE (State or foreign country) Port Deposit Rural			
13. FATHER'S NAME John Hall				12. CITIZEN OF WHAT COUNTRY? U.S.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT & ADDRESS Howard Wilson Rising Sun Md.				14. MOTHER'S MAIDEN NAME Priscilla Kyle			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
199. IMMEDIATE CAUSE (A) <u>Metastatic Carcinoma of the</u> ANTECEDENT CAUSE(S) DUE TO <u>fermur and Brain.</u> DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>Jan. 1</u>, 19<u>55</u>, to <u>6-10</u>, 19<u>56</u>, that I last saw the deceased alive on <u>6-10-56</u>, 19<u>56</u>, and that death occurred at <u>8:30A.M.</u> from the causes and on the date stated above. SIGNATURE <u>W.H. Dodson</u> ADDRESS (Street, city, town, state) <u>Rising Sun, Md.</u> DATE SIGNED <u>6-12-56</u></b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 14, 1956		NAME OF CEMETERY OR CREMATORIAL Brookview Cem.		LOCATION (City, town, or county) Rising Sun	
24. REC'D BY REGISTRAR, DATE <u>June 12-56</u>		REGISTRAR'S SIGNATURE <u>Z. M. Worthington</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Gysen</u>		ADDRESS <u>Rising Sun, Md.</u>	

CERTIFICATE OF DEATH

BUREAU V. 2

ON 13 1956

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06082  
91

Reg. Dist. No.

1  
 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Earlville</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton, R.D.4</b>		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>Eleanor</b>	Middle <b>Jean</b>	Last <b>Wooleyhan</b>	4. DATE OF DEATH	Month <b>6-26</b>	Day	Year <b>1956</b>
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-15-1932</b>		9. AGE (In years last birthday) <b>23</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House keeping</b>		11. BIRTHPLACE (State or Foreign country) <b>Earlville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Emerson Loller</b>				14. MOTHER'S MAIDEN NAME <b>Mary Louise Matthews</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <b>Emerson Loller, Earlville, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage from Gastric Ulcer</b> INTERVAL BETWEEN ONSET AND DEATH <b>540.0</b>								
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>Gall Stone Operation</b>								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>R.C. Dodson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		DATE SIGNED <b>6-27-56</b>						
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-29-56</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Elkton Cem.</b>		22d. LOCATION (City, town, or county) <b>Elkton</b> (State) <b>Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Loller</i>		ADDRESS <b>Wilmington, Md.</b>						
				24a. REC'D BY REGISTRAR DATE <b>JUL 3 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Mrs. Ralph Reed</b>		

WASHINGON STATE POLICE DEPARTMENT - SEATTLE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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